SENTARA LEIGH HOSPITAL
SENTARA NORFOLK GENERAL HOSPITAL

MEDICAL STAFF POLICIES

Approved October 7, 2014
### MEDICAL STAFF POLICIES

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Sentara Leigh Hospital and Sentara Norfolk General Hospital have an affiliation agreement with the Eastern Virginia Medical School for the education of residents and medical students. The care of each patient at Sentara Leigh Hospital and Sentara Norfolk General Hospital is the responsibility of an attending physician with medical staff appointment and clinical privileges. Medical staff members who are also faculty members at the Eastern Virginia Medical School supervise residents and medical students as they participate in the care of patients at Sentara Leigh Hospital and Sentara Norfolk General Hospital.

**Roles and Responsibilities**

The **attending physician** is responsible for, and is personally involved in, the care provided to individual patients. When a resident is involved, the attending physician continues to maintain personal involvement in the care of the patient as required in this policy. The attending physician will direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient’s condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised.

Each **program director** is responsible for the quality of overall residency education and for ensuring that the program is in compliance with the policies of the respective accrediting and certifying bodies. The program director defines the levels of responsibility for each year of training by preparing a description of types of clinical activities residents may perform. The program director monitors resident progress and ensures that problems, issues and opportunities to improve education are addressed.

The **Resident Evaluation Committee** is composed of the Assistant Dean of Graduate Medical Education, representing the Graduate Medical Education Committee, the President of the Medical Staff, the Chairman of the Best Practice Committee and the VPMA. The Resident Evaluation Committee ensures that communication takes place between the EVMS Graduate Medical Education Committee and Sentara Leigh Hospital and Sentara Norfolk General Hospital regarding the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of the participants in the residency programs.
Supervision

While residents assume successively more responsibility with each year of their training program, all residents are supervised on a daily basis by the attending physician responsible for each patient. The attending physician is actively involved in the care of each patient. Evidence of daily supervision may be found through documentation of consultations and required approvals found in the progress notes of the medical record and on countersignatures to dictated reports, as well as written orders.

The following general principles apply to the supervision of residents and medical students.

1. Residents shall be allowed to write patient care orders and shall be supervised daily in their patient care activities by the attending physician responsible for the patient. Sufficient evidence shall be documented in the medical record to substantiate the active participation in, and supervision of, the patient's care by such supervising physician. All surgery is performed under the direct supervision of an attending physician.

2. Residents may not write orders for chemotherapy drugs.

3. All residents must be supervised during the provision of Moderate Sedation in accordance with approved Hospitals policies. Evidence of supervision for the History & Physical, pre-assessment, ASA assessment, and choice of medication must be documented in the medical record for patients receiving Moderate Sedation.

4. Residents may order restraints and seclusion upon successful completion of an assessment administered by the Eastern Virginia Medical School and approved by the medical staff.

5. Evidence of adequate personal supervision by attending physicians may be found through progress notes and countersignatures on dictated reports by the attending physician. Countersignatures may be by written signature, initials, or computer key. Clinical Discharge/Transfer summaries dictated by PGY1s and PGY2s must be countersigned by an attending physician who is a member of the medical staff. History and Physicals and Operative Reports dictated by a resident who is not a member of the medical staff must be countersigned by an attending physician who is a member of the medical staff.

6. Any staff member with a question about the level of supervision provided to a resident or whether a resident should perform a procedure should contact the resident's attending physician directly.
Emergency Department

Emergency Medicine residents are supervised in the Emergency Department by an attending Emergency Medicine physician. The care of each patient seen by a first year Emergency Medicine resident is presented to and approved by the attending physician as evidenced by a countersignature on the chart prior to the patient’s discharge from the Emergency Department. PGY2 and PGY3 residents in Emergency Medicine achieve more independence with seniority.

Residents in Family Medicine, Internal Medicine, and Obstetrics and Gynecology rotate through the Emergency Department as a part of their training programs and all work under the supervision of the Emergency Medicine attending physician. Family Medicine residents must present all patients to the Emergency Medicine attending physician who must co-sign all residents charts. PGY1 residents in Internal Medicine rotating through the Emergency Department work under the supervision of members of the medical staff in Emergency Medicine and also work with and receive supervision from upper level residents (PGY2 and PGY3) in the Emergency Medicine residency program. Residents in Obstetrics and Gynecology rotate through the Emergency Department in their first year of residency and function as any other PGY1 resident does.

Upper level residents in Obstetrics and Gynecology serve as consultants to Emergency Medicine physicians; patients with emergent obstetrical or gynecologic problems are managed jointly by the OB/GYN residents and the Emergency Department staff.

Intensive Care Units

Internal Medicine residents complete an ICU rotation. Attending physicians supervising these residents approve all admissions to the ICU and all consults provided by these residents once the initial evaluations are performed. Attending physicians see patients in the ICUs managed by the Internal Medicine residents on a daily basis, along with those residents. All patient transfers out of the ICUs are approved by the attending physician.

Attending Surgery staff supervise the residents at all levels on the Surgical Service responsible for patients in the ICUs in accordance with the principles of graduated responsibility set forth above.

Maternal Fetal Medicine faculty primarily manages all critically ill obstetrics patients in the perinatal ICU suite on L&D at Norfolk General or in one of the other ICUs at Norfolk General.
Level II Nursery at Sentara Norfolk General Hospital

All patients in the Level II Nursery are managed by either a neonatologist, community based pediatrician, or community based family practitioner. The attending physician supervises the pediatrics residents and the family practice resident in the daily activities and procedures in this unit.

Medical Students

Medical students are supervised by a member of the medical staff or by a resident for all of their involvement in patient care. The ultimate responsibility for the care of individual patients remains with the attending physician. For interviewing, patient cases are presented to either a resident or a member of the medical staff. For physical examination, findings are presented and reviewed. For the interview and physical examination cases presented to the resident or attending physician, that resident or attending physician independently confirms the essential elements. For medical procedures, with the patient’s consent, students may perform certain procedures under the direct supervision of a member of the medical staff or a resident. A resident may not supervise a medical student in procedures that resident requires supervision. All medical records and patient orders written by medical students are reviewed and co-signed by either a member of the medical staff or a resident, in addition to their own independent documentation of patient care.

The supervision shall take the following specific forms:

- Medical students may dictate operative reports, but they must be reviewed and signed by the attending physician.
- Medical students may dictate History & Physical and Discharge Summaries, but they must be signed by a PGY3 or above or an attending physician. The attending physician also independently confirms the essential elements of care of the History & Physical and the decision making portion of all patient interactions.
- Medical students may write progress notes, but they must be signed by an attending physician, who also documents independently.
- Medical students may not give verbal orders.
- Medical students may write orders, but they must be signed by a resident or attending physician before they are carried out.

Communication

Appropriate resident job descriptions (by year of training) – “Progressive Scopes of Responsibility” will be available in the Patient Care Supervisors’ offices and in Surgical Services to accurately reflect residents’ progression. These are updated by the training programs on an annual basis.
These competencies reflect the patient care services that may be performed by the resident and the level of supervision required.

**Hospitals’ Monitoring of Supervision**

The Vice Presidents for Medical Affairs (VPMAs) at Sentara Norfolk General Hospital and Sentara Leigh Hospital are responsible for ensuring that the facilities fulfill all responsibilities identified in this section.

Along with the VPMAs, each residency program director is responsible for monitoring resident supervision, identifying action plans and devising plans of action for their remedy.

At a minimum, the monitoring process will include:

- a review of compliance with inpatient and outpatient documentation requirements, as part of medical record reviews;
- a review of all serious adverse events with complications to ensure that the appropriate level of supervision occurred;
- a review of all accrediting and certifying bodies’ concerns and followup actions
- a general review and discussion of resident evaluations of their residency experience;
- an analysis of events where violations of graduated levels of responsibility may have occurred.

Reviews pertaining to resident performance and supervision will be communicated, at a minimum, on an annual basis, to the Medical Executive Committee and to the Governing Body.

**December, 2004**

*Updated February 1, 2011*
Purpose:

It is the purpose of this document to provide guidelines for the proper and appropriate evaluation and action regarding a report of suspected practitioner impairment. This policy complies with the Virginia Code regarding report of practitioner impairment. This policy establishes procedures to properly evaluate and act upon concerns that a practitioner is suffering from an impairment as defined herein. This policy also establishes guidelines for education of Medical Staff members and Hospitals staff regarding issues about illness and impairment recognition issues specific to Medical Staff members.

Policy:

It is the policy of the Hospitals and their Medical Staff to properly evaluate and act upon concern that a practitioner is suffering from an impairment. The Hospitals through their Medical Staff, will conduct an evaluation and act in accordance with applicable state and federal law.

Definition of Impairment:

The American Medical Association defines the Impaired Practitioner as “one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.”

§54.1-25.5 of the Virginia Code defines “Impairment” as a physical or mental disability, including, but not limited to, substance abuse that substantially alters the ability of a practitioner to practice his profession with safety to his patients and the public.

Because the term “Impaired Practitioner” includes a variety of problems, from substance abuse to physical or mental illness, the steps provide herein will serve as guidelines and may therefore be modified to suit individual circumstances. This policy does not in any way grant any additional rights to the practitioner not provided by the Medical Staff Bylaws.
Report and Evaluation

If any individual working in the Hospitals has a reasonable belief that a Medical Staff member or Allied Health Professional is impaired, the following steps should be taken:

1. The individual who suspects the Medical Staff member or Allied Health Professional of being impaired must give a written report to the President of the Medical Staff. The report shall include a description of the incident(s) that led to the belief that the Medical Staff member or Allied Health Professional might be impaired. The individual making the report does not need to have proof of the impairment, but must state the facts that led to the concerns.

2. If, after reviewing the report, the President of the Medical Staff believes there is enough information to warrant an evaluation, the President of the Medical Staff shall request that a review be conducted and a report of its findings rendered by:
   a. the President of the Medical Staff;
   b. a standing committee of the Medical Staff;
   c. an outside consultant; or
   d. another individual(s) appropriate under the circumstances

3. If the review produces sufficient evidence that the Medical Staff member or Allied Health Professional is impaired, the President of the Medical Staff and the evaluator shall meet personally with that Medical Staff member or Allied Health Professional or designate another appropriate individual(s) to do so. The Medical Staff member or Allied Health Professional shall be told that the results of an evaluation indicate that the Medical Staff member or Allied Health Professional suffers from an impairment that affects his or her practice. The Medical Staff member or Allied Health Professional should not be told who filed the report, and does not need to be told the specific incidents contained in the report.

4. The written report and a written summary of the results of the investigation shall be forwarded to the Medical Executive Committee. The Medical Executive Committee has the following options:
a. Approve an acceptable voluntary restriction on the Medical Staff member or Allied Health Professional's privileges or scope of practice, as appropriate, as well as participation in an approved rehabilitation program;

b. Require the Medical Staff member or Allied Health Professional to undertake a rehabilitation program as a condition of continued appointment and clinical privileges;

c. Impose appropriate restrictions on the Medical Staff member's or Allied Health Professional's practice;

d. Impose any action necessary to protect patients and staff;

e. Summarily suspend the Medical Staff member's or Allied Health Professional's privileges or scope of practice in the Hospitals until rehabilitation has been accomplished, if the Medical Staff member or Allied Health Professional does not agree to discontinue practice voluntarily.

If the Medical Executive Committee recommends any action, which constitutes an adverse action under Article 7.1 of the Medical Staff Bylaws or Section 8 of the Policy on Allied Health Professionals, the Medical Staff member or Allied Health Professionals shall have the appeal rights set forth in Article VII of the Bylaws or Section 8 of the Policy on Allied Health Professionals, as applicable.

5. The Hospitals shall seek the advice of Hospitals legal counsel to determine whether any conduct must be reported to law enforcement authorities or other government agencies, and what further steps must be taken.

6. The original report and a description of the actions taken should be included in the Medical Staff member or Allied Health Professional's credentials file. If the evaluation reveals that there is no merit to the report, the report shall be destroyed. If the review reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the Medical Staff member’s or Allied Health Practitioner’s credentials file and the Medical Staff member’s or Allied Health Practitioner’s activities and practice shall be monitored until it can be established whether there is an impairment problem.

7. The administrator or President of the Medical Staff shall inform the individual who filed the report that the follow-up action was taken.
8. Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussion of this matter with anyone outside those described in this policy.

9. In the event there is an apparent or actual conflict between this policy and the bylaws, rules, and regulations, or other policies of the Hospitals or their Medical Staff, including the due process sections of those bylaws, manuals, and policies. The provisions of this policy shall supersede such bylaws, manuals, rules, regulations, or policies.

10. A Medical Staff member or Allied Health Practitioner who believes he or she is impaired should report this to the President of the Medical Staff. The President of the Staff shall then refer the practitioner to a suitable program for evaluation. A copy of the evaluation shall be provided to the President of the Medical Staff. The President of the Medical Staff shall attempt to reach a voluntary agreement with the Medical Staff member or Allied Health Professional regarding his or her continued practice in the Hospitals. If a voluntary agreement is reached, the Medical Executive Committee must approve it. If no voluntary agreement is reached, the matter shall be referred to the Medical Executive Committee for action under Item 4 above.

Rehabilitation

11. The Hospitals and Medical Staff leadership shall assist the Medical Staff member or Allied Health Professional in locating a suitable rehabilitation program. The Hospitals shall not reinstate a Medical Staff member or Allied Health Professional until it is established, to the Hospitals satisfaction, that the Medical Staff member or Allied Health Professional has successfully completed a rehabilitation program in which the Hospitals has confidence.

Reinstatement

12. Upon sufficient proof that a Medical Staff member or Allied Health Professional who has been found to be suffering an impairment has successfully completed a rehabilitation program, the Hospitals may consider reinstating that Medical Staff member or Allied Health Professional to the Medical or Affiliate Staff.

13. When considering an impaired Medical Staff member or Allied Health Professional for reinstatement, the Hospitals and its Medical Staff leadership must consider patient care interests to be paramount.
14. The Hospitals must first obtain a letter from the physician director of the rehabilitation program where the Medical Staff member or Allied Health Professional was treated.

The Medical Staff member or Allied Health Professional must authorize the release of this information. The letter from the director of the rehabilitation program shall state:

a. whether the Medical Staff member or Allied Health Professional is participating in the program;

b. whether the Medical Staff member or Allied Health Professional is in compliance with all of the terms of the program;

c. whether the Medical Staff member or Allied Health Professional attends program meetings regularly (if appropriate);

d. to what extent the Medical Staff member or Allied Health Professional’s behavior and conduct are monitored;

e. whether, in the opinion of the rehabilitation program physicians, the Medical Staff member or Allied Health Professional is rehabilitated;

f. whether an after-care program has been recommended to the Medical Staff member or Allied Health Professional and, if so, a description of the after-care program; and

g. whether, in the program director’s opinion, the Medical Staff member or Allied Health Professional is capable of resuming medical practice and providing continuous, competent care to patients.

15. The Medical Staff member or Allied Health Professional must inform the Hospitals of the name and address of his or her primary care physician, and must authorize the physician to provide the Hospitals with information regarding his or her condition and treatment. The Hospitals have the right to require an opinion from other physician consultants of its choice.

16. The Hospitals shall request the primary care physician to provide information regarding the precise nature of the Medical Staff member or Allied Health Professional’s condition, the course of treatment, and the answers to the questions posed above in 14 (e) and (g).
17. If the Hospitals do not receive required information or if a required rehabilitation program is not completed, the Medical Staff member or Allied Health Professional’s application for reinstatement will be considered incomplete, and he/she will not be reinstated.

18. Assuming all information the Hospitals receive indicates that the Medical Staff member or Allied Health Professional is rehabilitated and capable of resuming patient care, the Hospitals must take the following additional precautions when restoring clinical privileges or scope or practice:

a. the Medical Staff member or Allied Health Professional must identify two Medical Staff members or Allied Health Professionals who are willing to assume responsibility for the care of his or her patients in the event that he or she is unable or unavailable to care for them;

b. the Hospitals shall require the Medical Staff member or Allied Health Professional to provide the Hospitals with periodic reports from his or her primary care physician – for a period of time specified by the President of the Medical Staff – stating that the Medical Staff member or Allied Health Professional is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the Hospitals is not impaired.

19. The department chief or physician appointed by the department chief shall monitor the Medical Staff member or Allied Health Professional’s exercise of clinical privileges in the Hospitals. The Credentials Committee shall determine the nature of that monitoring after reviewing all of the circumstances.

20. All requests for information concerning the impaired Medical Staff member or Allied Health Professional shall be forwarded to the Medical Staff Office for response.

21. Medical Staff leadership will arrange for educational presentations regarding issues surrounding illness and impairment recognition issues specific to physicians for a general meeting of the Medical Staff and/or the Medical Executive Committee or other appropriate groups of physicians as frequently as is necessary. Finally, Medical Staff leadership and Administration will arrange for presentation to be made to Hospital managers/staff regarding illness and impairment recognition issues specific to physicians as deemed appropriate.

Revised January 5, 2010
Updated February 1, 2011
Policy

The Medical Staff will recommend that temporary privileges be granted to applicants for medical staff membership upon request of the applicant if the applicant has a complete application that meets specific criteria awaiting review and approval of the Credentials Committee, Medical Executive Committee and the Governing Body. The Medical Staff will also recommend that temporary affiliate staff membership be granted upon request of the applicant under the same circumstances as those defined for medical staff applicants.

Procedure

1. In order to be eligible for temporary privileges or affiliate staff membership, the application must be complete. “Complete” is defined as all questions on the applications answered, all primary sources required to be verified have been verified, and all resulting questions answered. An application will no longer be deemed “complete” when new questions arise.

Applicants who have not completed the residency or fellowship training program in which they are currently enrolled are not eligible for medical staff membership and clinical privileges until they have completed the training program and this has been verified by the Sentara Hospitals Credentialing Office. Until this verification has been completed, the application is considered incomplete.

2. Once the application is “complete” temporary privileges may then be considered. A complete application may be considered for temporary privileges if it meets the criteria listed below:

   A. There are no current or previously successful challenges to licensure or registration.
   B. The applicant has not been subject to involuntary termination of medical staff membership at any organization.
   C. The applicant has not been subject to involuntary limitation, reduction, denial, or loss of any clinical privileges at any organization.
   D. There are no negative or questionable recommendations (ratings of Fair or Poor) from any primary source in any one of the following areas:
Basic Medical Knowledge
Competency & Skill
Patient Management
Professional Judgment
Sense of Responsibility

The applicant is not eligible for temporary privileges/appointment if any primary source has rated him/her “Good-Fair” or “Good/Fair” in many or all of the areas listed above.

The applicant may not be eligible for temporary privileges/appointment if a primary source has rated the applicant “Fair” or “Poor” in any other area.

E. There are no discrepancies in information received from the applicant or primary sources or references.
F. The applicant completed a normal education/training sequence.
G. No Medical Staff Members, the CEO or his designee have concerns with the malpractice claims history.
H. The applicant has submitted a reasonable request for clinical privileges based on experience, training, and competence and is in compliance with applicable criteria.
I. The applicant reports an acceptable health status.
J. The applicant has never been sanctioned by a third-party payer (e.g., Medicare, Medicaid).
K. There are no convictions on the criminal history background check report with the exception of minor traffic violations.

If the application does not meet the criteria described above, the applicant will not be eligible for temporary privileges at any time, although the application will still be considered for permanent privileges and/or membership, as applicable.

3. There will be an additional fee of $500 payable to the Sentara Hospitals-Norfolk Medical Staff fund for each applicant for temporary privileges. This fee must be received prior to temporary privileges being granted.

4. In order to be granted temporary membership and/or privileges, an application must be reviewed and recommended by all of the following:

A. Department chairman/chief;
B. Member of the Credentials Committee;
C. Chairman of the Credentials Committee; and
D. President/Chief of Staff/Chairman of the Medical Executive Committee
If any of the individuals named above recommends that temporary privileges not be granted, the application becomes ineligible for temporary privileges.

If an application has already been recommended for privileges by the department chairman, the Credentials Committee member and chairman and the Chief of Staff and a request is made for temporary privileges, the application does not have to be recommended specifically for temporary privileges.

5. An application for temporary privileges for an eligible applicant will be considered and acted upon within five (5) business days. Weekends and holidays are not included. If the application is not acted upon within five (5) business days and no questions or needs for additional information have been identified, the $500 fee will be refunded. If any of the individuals named in Item #3 requests additional information or clarification on the application, it will again be considered incomplete. In this situation, medical staff leadership reserves the right to require additional time beyond the normal five (5) business day turnaround time to resolve any concerns that arise regarding the application.

6. Temporary staff membership and privileges will be granted for no more than 120 days.

7. The applicant and/or their professional group will be notified that temporary privileges have been granted by facsimile or email as soon as the privileges are granted. Repeated calls to the Medical Staff Office regarding the status of the application will not expedite the process.

Updated February 1, 2011
Revised October 2, 2012
MEDICAL RECORDS POLICY
RULE #32 OF THE RULES AND REGULATIONS

Each practitioner shall be subject to the following requirements concerning medical records, as well as to any specific departmental requirements concerning medical records, which are incorporated herein by reference.

1. **General Statement**

   The attending practitioner shall be held responsible for the preparation of a complete, inpatient and/or outpatient medical record which incorporates all significant clinical information for each patient contact. The record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results accurately.

2. **Content of Inpatient Medical Record**

   All inpatient medical records shall include:

   a. Identification data

      1) Patient’s name, address, next of kin, and medical record number
      2) If unobtainable, the reason shall be stated

   b. Medical history

      1) Chief complaint
      2) Details of present illness, including, when appropriate, an assessment of the patient’s emotional, behavioral, and social status
      3) Relevant past, social and family histories, appropriate to the age of the patient
      4) Current Medications

   c. Pertinent review of systems

   d. Physical examination

   e. Provisional diagnosis - A statement of conclusions or impressions drawn from the admission history and physical examination.

   f. Plan of care
1) A statement of the course of action planned for the patient while in the hospital to include a periodic review, as appropriate.

2) When care is not planned to meet all identified needs, this is documented in the medical record.

g. Consent

1) Consents should be obtained when necessary, consistent with hospital policy and should be adequately documented.

2) If unobtainable, the reason is stated.

h. Progress notes - Daily entries reflecting the physician’s personal clinical observations, pertinent chronological report of the patient’s course in the hospital, changes in the condition of the patient, and results of treatment.

i. Consultation reports (where appropriate) – Documented opinion of the consultant that reflects, when appropriate, a personal examination of the patient and the patient’s medical record(s)

j. Nurses’ notes

k. Support services’ notes

l. Reports of procedures, tests, and results (as appropriate)
   These reports are completed and available in the medical record promptly (within 24 hours, whenever possible). Reports from other facilities may be used if the facility is identified in the report.

   1) Diagnostic/therapeutic procedures
   2) Operative reports
   3) Pathology reports
   4) Clinical laboratory reports
   5) Radiology reports
   6) Nuclear medicine reports
   7) Anesthesia records

m. Conclusions at the termination of treatment

   1) Reason for admission/treatment

   2) Principal diagnosis recorded legibly in acceptable terminology without the use of symbols or abbreviations
3) Associated diagnoses recorded legibly in acceptable terminology that includes topography and etiology without the use of symbols or abbreviations.

4) Operative procedures (if any)
   a) Recorded legibly in acceptable terminology
   b) Descriptions of findings, technical procedures used, specimens removed, pre and post-operative procedure diagnosis and name of physician and any assistants and estimated blood loss.

5) Hospital course and (significant findings) treatment rendered

6) Condition of patient at discharge. Provides specific measurable comparison with the condition on admission and avoids the use of vague terminology such as “improved”.

7) Events leading to patient’s death (if appropriate)

8) Instructions given to the patient and/or family
   a) Diet
   b) Physical activity
   c) Medication
   d) Follow-up care

   Note: When pre-printed instructions are given, this is noted in the medical record and a sample of the instruction sheet in use at the time is on file in the Health Information Services Department.

n. Autopsy report (if applicable) - A provisional anatomical report is filed in the medical record within 3 days and a complete report within 60 days, unless exceptions for special studies have been established by the Medical Staff.

o. For patients with problems of a minor nature staying 48 hours or less, normal newborn infants and uncomplicated obstetrical deliveries, a final progress note may be substituted for the discharge summary. The final progress note shall contain any instructions given to the patient and/or family. Each Medical Staff Department shall have the right to designate the format/location of any substitution for the final progress note.
3. **Content of Outpatient Medical Record**

The content of outpatient medical records shall be determined by the policy of the relevant program, department and/or operating center. These policies shall be approved and signed by the administrative director, medical director for the program, department, and/or operating center, Administrative staff, as well as the Director of Health Information Services and the medical staff when appropriate.

4. **Patient History and Physical**

1. **Inpatient**

1) The medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or procedure requiring anesthesia services, which includes deep and/or moderate sedation. The medical history and physical examination must be completed by a physician, an oral & maxillofacial surgeon, podiatrist or other qualified licensed individual in accordance with State law and hospital policy. When the H&P is conducted within 30 days before admission or registration, an updated examination of the patient, including any changes in the patient’s condition must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral & maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. If there are no changes to the H&P, the update note must include: a) H&P has been reviewed; b) physician concurs with findings of the H&P on specified date; and c) patient has been examined. If there are changes, update note should document physician’s concurrence with the H&P conducted on the specified date “with the following additions and/or exceptions”. Update note must be timed, dated and signed.

Reports from other facilities or from non medical staff members may be used if reviewed at the time of admission or registration, but prior to surgery or a procedure requiring anesthesia services, by a Medical Staff member or other individual who has been authorized by the hospital to perform H&Ps. Update note should follow documentation requirements as cited in above paragraph. The history and physical may incorporate by
reference other documents from other facilities. In the event the history and physical examination is not dictated, an initial progress note defining the problem must be written on the chart within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

If a patient is readmitted for treatment of the same or related problem within 30 days following discharge from the hospital the history and physical from that admission may be used, if appropriate. Otherwise, if the admission problem is markedly unrelated to the prior admission, a new H&P should be done. The H&P must be reviewed and updated (as previously cited in paragraph “1” of this section) to include changes which may have occurred since the report. These changes or documentation of no change will be recorded in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

H&Ps or nursing assessment older than 30 days may be used as reference/addendum information “only” if information is still relevant and current. A new H&P must still be performed within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

In an emergency, when there is no time to record the complete history and physical examination, a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record before surgery.

A consultation report may be used as a History & Physical when it meets the content requirements and other Medical Staff Bylaws/Rules and Regulations requirements of a History & Physical and if the consultant has been authorized to perform H&Ps.

Obstetrical records shall include all prenatal information. A durable, legible original or copy of the office of clinic prenatal record is acceptable. The prenatal records may be used as the History and Physical provided these records meet the components of a History and Physical.
2) A patient undergoing a procedure must first be determined appropriate for that procedure. That determination is based on all relevant factors, which may include the patient’s history and physical status, the results of diagnostic tests, the risks and benefits of the contemplated procedure and the potential need to administer blood or blood components.

If the patient undergoes a surgical procedure, the patient’s physical examination and medical history, the results of any indicated diagnostic tests and a preoperative diagnosis are completed and the results are recorded in the patient’s medical record prior to surgery.

If the patient undergoes an invasive procedure, with or without anesthesia and moderate or deep sedation, a history and physical should be completed and recorded in the patient’s medical record prior to procedure.

3) The content of the history and physical shall be determined by an assessment of the patient’s condition and any co-morbidities in relation to the reason for admission or surgery. It should include an assessment of the patient’s condition and the treatment plan.

Based on the patient’s illness, extent of problem and type of procedure, parts of the history and physical may be deferred.

For emotional or behavioral patients, the patient’s current mental, emotional and behavioral function must be described, and there must be a mental status examination.

For children and adolescents, the history and physical must also include the following:
- evaluation of developmental age
- consideration of educational needs and daily activities
- immunization status (document or parent’s report)
- family expectations for involvement in the care of the patient

2. Outpatient

1) For outpatient surgery (diagnostic/therapeutic), and any invasive or non-invasive procedures requiring anesthesia services (including those in which deep or moderate sedation is administered), a history and physical examination is required and must be documented in the patient’s medical record prior to
surgery or the procedure. At the discretion of the physician, a history and physical performed within 30 days of surgery or procedure may be used provided an updated examination of the patient, including any changes in the patient’s condition, be completed and documented in the patient’s medical record prior to surgery or procedure. The update note must include: a) H&P has been reviewed; b) physician concurs with findings of the H&P on specified date; and c) patient has been examined. If there are changes, update note should document physician’s concurrence with the H&P conducted on the specified date “with the following additions and/or exceptions. These changes or documentation of no change will be recorded in the patient’s medical record. Update note must be signed, dated and timed by a member of the Medical Staff if personally performed by that practitioner or a member of the same professional group (or other qualified licensed individual in accordance with State law and hospital policy) at the time of service. A history and physical examination is required for outpatient surgery cases regardless of the type of anesthesia planned and/or given, as well as, when no anesthesia is given.

MINIMAL REQUIREMENTS FOR HISTORY AND PHYSICAL FOR AMBULATORY SURGERY AND INVASIVE PROCEDURES:

a) Indications/symptoms for procedure;
b) Planned procedure;
c) A list of current medications and dosages;
d) Any known allergies, including medication reactions; and
e) Existing comorbid conditions, if any.
f) an examination specific to the procedure proposed to be performed and any comorbid conditions;  and
g) Examination of the heart and lungs by auscultation.
h) Assessment and statement about the patient’s general condition.

2) Histories and physicals from other facilities or from non Medical Staff members may be used provided a Medical Staff member or other individual who has been authorized by the hospital reviews, concurs with findings of the H&P on specified date; examines patient and includes any changes which may have occurred since the report prior to surgery or procedure. Changes or documentation of no change will be recorded in the patient’s medical record prior to surgery. Entry must be signed, dated and timed by a member of the Medical Staff if personally performed by that practitioner or member of the same
professional group in accordance with State law and hospital policies.

Ambulatory departments in which invasive procedures or procedures that pose a significant risk to patients are performed will have policies and procedures that define the specific time frames for procurement of histories and physicals prior to the procedure and specific procedures requiring histories and physicals as applicable. This would apply to such departments as the Medical Procedure Unit, Radiology, etc. These departments are examples only and not intended to include all departments to which this requirement applies.

3. Newborn Records

- A separate medical record shall be maintained for each newborn infant. Such record shall include notes of gestational history, including any pathology and information regarding complications at delivery and mother’s medication during labor and delivery.

5. Entries in and Authentication of the Electronic Medical Record

A. All entries in the medical record shall contain pertinent, meaningful observations and information dated, timed and authenticated by the person making the entry. Documentation should be done as soon as possible after each occurrence. Verbal and Telephone Orders must be signed, dated and timed within 2 calendar days. Opinions requiring medical (physician) judgment may be recorded only by individuals who have been granted clinical privileges, and by house staff in accordance with applicable requirements concerning supervision of same. If physician documentation duties have been delegated to a non-physician, the physician responsible for the patient shall authenticate all information. Authentication may be by entered signature, initials, or computer key. Each physician will be given a unique computer key (code), if desired, which is to be used by the physician only.

B. Documentation may be replicated utilizing the “copy forward” or “copy and paste” functions embedded in the electronic medical record. The principle of veracity should govern text replication. Any use of data replication must accurately reflect the clinical situation and work performed by the final author. Text replication requires careful editing of content for accuracy.
C. Text, excluding material from diagnostic reports, copied from a provider other than the author or member of the author’s service requires attribution. Proper attribution references the source and origination date of the copied material. The following would be an example of proper attribution. As per Dr. Smith’s Emergency Department evaluation on 4/1/14, “The patient reported no fever, chills or purulent sputum.”

D. As records are constantly being reviewed by various entities within Sentara Healthcare (such as peers, care coordination, coding and nursing), it may become apparent from time to time that a provider is indiscriminately replicating data from sources without proper attribution or sufficient accuracy. Such cases may be referred to peer review and considered for further audits and corrective action to ensure that data is appropriately replicated. Providers will be given ongoing feedback and opportunity for improvement. Attendance at a Provider eCare Proficiency Course may also be recommended.

6. Requirements for All Patients Undergoing Surgery

All patients undergoing surgery will have a pre-operative diagnosis recorded and authenticated by the practitioner(s) responsible for the patient prior to surgery. If the history and physical examination are not recorded before the time stated for the operation, the operation shall be canceled unless the attending surgeon documents that such a delay would constitute a hazard to the patient and completes, prior to the commencement of surgery, the pertinent history and physical findings.

7. Availability of the Medical Record at the Time of Surgery

The patient’s medical record shall be available in the surgical suite at the time of surgery and shall contain at least the history and physical examination, evidence of appropriate informed consent, results of indicated diagnostic tests, and a pre-operative diagnosis.

8. Immediate Postoperative Note

An immediate postoperative note will be documented in the progress notes, and shall contain at least the pre-operative diagnosis, a description of the findings, the technical procedures used, the specimens removed, the post-operative diagnosis, blood products administered, any grafts or implants utilized, the name of the primary surgeon and any assistants (physician, physician assistant or resident). Operative/procedure (diagnostic/therapeutic/organ/tissue donation) notes will be dictated or entered into the electronic medical record.
9. **Specimens**

All specimens removed at operation with exceptions permitted by hospital policy shall be sent to the hospital pathologist, who shall make such examinations as he may consider necessary to arrive at a pathological diagnosis, and shall render a report of his findings to be a part of the patient’s permanent hospital record.

10. **Requirements for Patients Receiving Anesthesia**

For all patients receiving anesthesia the following are recorded in the patient’s medical record:

- There is a pre anesthesia assessment which includes a determination that the patient is an appropriate candidate for the planned anesthesia;
- Anesthesia options and risks are discussed with the patient and family prior to administration;
- The patient is assessed immediately before anesthesia induction;
- The patient’s physiological status is monitored during anesthesia administration;
- The patient’s post procedure status is assessed on admission to and before discharge from the post anesthesia recovery area.
- Patients are discharged from the post anesthesia recovery room by a physician or by Hospitals policy.

11. **Ownership of Medical Records**

All medical records are the property of Sentara Hospitals – Norfolk, and copies of medical records shall be produced in response to authorized requests pursuant to hospital policy. Original records may be removed from the Hospitals’ premises only to support hospital operations and under the supervision of authorized Sentara employees or by court order.

12. **Medical Records Completion Policies**

All records shall be completed within 14 days post discharge/service date. A record is considered complete when the required contents have been entered into the record (including transcribed reports) and authenticated, when all queries from coding have been answered, and when all final diagnoses and complications have been recorded. Records greater than 14 days post-discharge/service shall be considered delinquent.

**FIRST NOTICE**: Once a record has been deemed delinquent, the Health Information Services Department will notify the practitioner via the physician’s “in-basket” in EPIC under the “Staff Messages” folder that the
practitioner has delinquent records and that all current discharged records that need to be completed within 14 days from the date of this first notice.

**FINAL NOTICE:** Seven (7) days after the first notice, personnel from the Health Information Services Department will notify the practitioner via the physician’s "in-basket" in EPIC under the "Staff Messages" folder that if those records from the first notice remain incomplete after seven (7) days from the date of the FINAL NOTICE, he/she will not be permitted to admit patients, schedule surgery or perform any type of surgery, outpatient/diagnostic procedure or otherwise until all delinquent records have been completed.

Two (2) days prior to suspension a courtesy telephone call will be made to the potentially suspended practitioner and practice administrator to ensure that he/she is aware of the impending suspension action. Failure to communicate personally with the practitioner shall not prevent the termination of admitting privileges under this regulation.

**SUSPENSION NOTICE:** On the day of suspension, the Health Information Services Department will notify the suspended practitioner via the physician’s "in-basket" in EPIC under the "Staff Messages" folder that he/she is not permitted to admit patients, schedule surgery or perform any type of surgery, outpatient/diagnostic procedure or otherwise until all delinquent records have been completed.

Suspensions, as stated above, will occur 14 calendar days following the date of the FIRST NOTICE. If this day is on a weekend, suspension will occur the following Monday. On the day the practitioner’s admitting privileges are to be terminated, a courtesy telephone call will be made to the practitioner’s office to ensure he/she is aware of the impending action. Failure to make this call shall not prevent the termination of admitting privileges under this regulation.

If either ill or absent from the city, the practitioner will be excused by the Health Information Services Department for a reasonable period of time. Should the practitioner have an emergency admission denied because of having delinquent records, and should he/she not wish to refer the patient to another hospital or another doctor for admission, he/she may call the Health Information Services Department and request a twenty-four (24) hour courtesy extension. Admitting privileges may be restored after records have been satisfactorily completed. Only one courtesy extension will be approved for these delinquent records.

If a practitioner has still failed to complete delinquent records 14 days after his/her admitting privileges have been terminated as provided above, the practitioner’s clinical privileges shall be automatically suspended and
access to eCare will be terminated. The Vice President of Medical Affairs shall be responsible for making the recommendation to the President of the Medical Staff that all privileges be automatically suspended pursuant to Section 6.4.3 of the Medical Staff Bylaws. Once privileges have been suspended, reinstatement will require a $500 reinstatement fee. The Vice President of Medical Affairs will coordinate with Information Technology and Health Information Management for limited access to eCare for the physician for record completion. Complete access to eCare will not occur until the reinstatement fee has been received by the Medical Staff Office.

13. **Completion of a Medical Record When the Physician Cannot Complete the Record**

The Physician Advisors to Health Information Services shall have the authority to order the filing of any records left incomplete because of the death, retirement, relocation out of the area, or suspension/revocation of privileges of a practitioner. When this procedure is followed, a note of explanation shall be filed in the medical record and signed by one of the Physician Advisors to Health Information Services. No record shall be completed by a practitioner unless he/she is familiar with the patient.

14. **Use of Symbols and Abbreviations**

Symbols and abbreviations designated by the Medical Executive Committee as unacceptable may not be used in the medical record. No symbols or abbreviations may be used in the recording of the final diagnosis.

15. **Assignment of Physician Primarily Responsible for the Patient's Care for Coding Purposes**

Each department or division of the Medical Staff shall have on file in the Health Information Services Department the mechanism for assigning the physician primarily responsible for the patient’s care for coding purposes.

16. **VHQC Coding Questions**

Virginia Health Quality Center coding questions to the practitioner pertaining to the sequencing and ordering of the diagnoses and procedures (as listed on the coding summary) shall be forwarded to the Health Information Services Department for comment prior to submission to the Virginia Health Quality Center.

*Revised October 7, 2014*
I. OVERVIEW

Given the unique structure and nature of the Department of Cardiac Services (the "Department"), the Department, consistent with its authority under Article IV, Section 4.7 of the Medical Staff Bylaws, has established a Department Credentials Committee and a Department Peer Review Committee, to assist the Department Chief in fulfilling his or her functions regarding credentialing and peer review which are outlined in Article IV, Section 4.6 of the Medical Staff Bylaws. By virtue of this Policy, these committees have been authorized and approved by the Sentara Leigh Hospital and Sentara Norfolk General Hospital Medical Executive Committee and are considered to be Medical Staff Committees. The composition and duties of these committees are set forth below.

II. CARDIAC SERVICES CREDENTIALS COMMITTEE

A. Composition

1. The Cardiac Services Credentials Committee (the "Credentials Committee") shall be composed of the following members who are appointed by the Department Chief:

   (a) The committee Chairman;
   (b) one representative from each physician practice that is a member of the Sentara Leigh Hospital and Sentara Norfolk General Hospital Department of Cardiac Services, and specializes in Cardiac Anesthesiology, Cardiac Surgery, and/or Cardiology services;
   (c) the Vice President of Cardiac, Vascular and Transplant Services;
   (d) the Director of Transplant, CHF and Research;
   (e) the Department Chief; and
   (f) the Department Vice Chief.

2. Each member of the Credentials Committee listed in Paragraphs (a)-(f) above shall be appointed for an initial term of one year, and may be reappointed by the Department Chief for additional terms.
3. Prior to serving on the Cardiac Services Credentials Committee, each member listed above shall have a signed attestation of confidentiality on file, to be reissued annually.

**B. Duties**

The Credentials Committee shall:

(a) recommend criteria for clinical privileges in the Department to the Sentara Leigh Hospital and Sentara Norfolk General Hospital Credentials Committee;

(b) review applications for initial appointment and clinical privileges and reappointment in the Department and make a report to the Sentara Leigh Hospital and Sentara Norfolk General Hospital Credentials Committee regarding whether the applicant has satisfied all of the qualifications for Medical Staff appointment and the clinical privileges requested;

(c) review and evaluate requests for clinical privileges to perform a significant new procedure or to use a significant new technique to perform a procedure, and

(d) prepare a report to the Sentara Leigh Hospital and Sentara Norfolk General Hospital Credentials Committee which addresses whether the Department and/or Hospital has the capabilities, including support services, to perform the new procedure and, if so, includes a recommendation as to the minimum education, training and experience that would be necessary to perform the new procedure or technique and the level of monitoring or supervision that would be necessary.

**C. Meetings**

The Credentials Committee shall meet quarterly or more often if necessary to accomplish its duties and shall maintain a permanent record of its proceedings and actions which shall be made available for review by the Sentara Leigh Hospital and Sentara Norfolk General Hospital Credentials and Medical Executive Committees.

**III. CARDIAC SERVICES PEER REVIEW COMMITTEE**

**A. Composition**

1. The Cardiac Services Peer Review Committee (the "Peer Review Committee") shall be composed of the following members who are appointed by the Department Chief, subject to approval by the President of the Medical Staff of Sentara Leigh Hospital and Sentara Norfolk General Hospital:

   (a) The committee Chairman;
representatives from each physician practice that is a member of the Sentara Leigh Hospital and Sentara Norfolk General Hospital Department of Cardiac Services, and specializes in Cardiac Anesthesiology, Cardiac Surgery, and/or Cardiology services; (c) the Vice President of Cardiac, Vascular and Transplant Services; (d) the Manager of Clinical Outcomes; (e) the Director of Cardiac Nursing; (f) the Department Chief; and (g) the Department Vice Chief.

2. Each member of the Peer Review Committee listed in Paragraphs (a)-(g) above shall be appointed for an initial term of one year, and may be reappointed by the Department Chief for additional terms.

3. Prior to serving on the Cardiac Services Credentials Committee, each member listed above shall have a signed attestation of confidentiality on file, to be reissued annually.

B. Duties

Notice of potential concerns shall be promptly brought to the attention of the Chair of the Peer Review Committee or the Manager of Clinical Outcomes. The Peer Review Committee shall:

1. identify opportunities to improve care within the Department;
2. report information to the Sentara Leigh Hospital and Sentara Norfolk General Hospital Medical Staff Peer Review Committee ("Medical Staff Peer Review Committee") to assist it in fulfilling its responsibilities;
3. provide the initial level of review for all cases in the Department in which there are:
   (a) deviations from the standard expectations regarding documentation and patient management;
   (b) patient injuries or risk of patient injuries;
   (c) adverse outcomes;
   (d) variances that fall outside of established norms or ranges; and
   (e) events that involve concerns with practitioner behavior.
4. prepare reports of the reviews conducted in Paragraph 3 for the Medical Staff Peer Review Committee in accordance with established Peer Review Process guidelines and Sections V -1,2,3 of this policy document. Data shall be handled and protected in accord with the Sentara Leigh Hospital and Sentara Norfolk General Hospital -Release of Data policy, with maintenance of anonymity and confidentiality.

C. Meetings and Reports

The Peer Review Committee shall meet quarterly or more often if necessary to accomplish its duties, shall maintain a permanent record of its proceedings and
actions, and shall report its recommendations, findings and actions to the Medical Staff Peer Review Committee.

IV. CONFLICT OF INTEREST

1. When performing a function outlined in this Policy, if any member of the Cardiac Services Credentials or Peer Review Committee has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with the conflict shall not participate in the final discussion or vote on the matter, and shall be excused from any meeting on the matter during that time. The individual with the conflict of interest also shall not participate in the preparation of any report or recommendation. However, the individual with the conflict of interest may provide relevant information and may answer any questions concerning the matter before leaving the meeting.

2. Any member of the Credentials or Peer Review Committee with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the appropriate Committee Chair. If unresolved, the Department Chief will make a final determination as to whether the provisions in this Section of the Policy shall be triggered.

3. The fact that a member of the Credentials or Peer Review Committee is in the same specialty or practice group as an individual whose performance or qualifications are being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No individual has the right to compel disqualification of another based on an allegation of conflict of interest.

4. The fact that a member of the Credentials or Peer Review Committee chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of an actual conflict of interest.

V. CONFIDENTIALITY AND PEER REVIEW

1. Actions taken and reports and recommendations made pursuant to this Policy shall be strictly confidential. The members of the Credentials and Peer Review Committees shall make no disclosures of any such information (discussion or documentation) outside of the meetings, except:
(a) when the disclosures are to another authorized committee or member of the Medical Staff or authorized Hospital employee, and are for the purpose of conducting legitimate credentialing and peer review activities;

(b) when the disclosures are authorized by Medical Staff or Hospital Policy; or

(c) when the disclosures are authorized, in writing, by the Administrator or by legal counsel to the Hospital.

2. All reports, recommendations, actions and minutes made or taken by members of the Credentials or Peer Review Committee are confidential and privileged pursuant to the Virginia peer review statute.

3. The Credentials and Peer Review Committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. ' 11101, et seq.

Updated February 1, 2011
Rule # 34

Except when consultation is precluded by emergency circumstances or is otherwise not indicated, the attending Medical Staff member shall consult on inpatients with another qualified member of the Medical Staff in the following general circumstances:

- when the diagnosis remains obscure after a thorough diagnostic evaluation has been completed;
- when there is doubt as to the choice of therapeutic measures to be used and consultation on inpatients by another Medical Staff member would be useful in making such a decision;
- for preoperative consultations, at the discretion of the surgeon; and
- in situations where specific skills of other Medical Staff members may be needed.

There are several specific circumstances in which consultation on inpatients by another Medical Staff member is required:

Physicians may manage ventilator patients for the first 24 hours of their illness if they have acute single organ failure or if they are chronic, stable ventilator patients. Physicians must obtain a Pulmonology/Critical Care Medicine consult for all mechanically ventilated patients who either do not meet the “Goals of Mechanical Ventilation” set forth below or who are ventilated in any mode for greater than 2 days.

Goals of Mechanical Ventilation:

1. Synchrony with the ventilator with minimal sedation
2. FiO2 < 50% with adequate oxygenation (SpO2 > 92%)
3. Peep < 8
4. Auto PEEP ≤ 6
5. Plateau Pressure < 35

All patients with the acute failure of more than one organ system (except trauma service patients) shall be admitted to the intensive care unit under the direct or consultative care of a physician certified by the American Board of Internal Medicine or Surgery in Intensive Care or with added qualifications in Critical Care.

Approved January 2, 2007
Updated February 1, 2011
This Policy outlines collegial and educational efforts that can be used by Medical Staff leaders to address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the process in the relevant Medical Staff governance document.

This Policy also addresses sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.

In dealing with all incidents of inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment free from sexual harassment are also critical.

All efforts undertaken pursuant to this Policy shall be part of the Hospital's performance improvement and professional and peer review activities.

GENERAL GUIDELINES/PRINCIPLES
Issues of employee conduct will be dealt with in accordance with the Hospital's Human Resources Policies. Issues of conduct by members of the Medical Staff or Allied Health Professionals (hereinafter referred to as "practitioners") will be addressed in accordance with this Policy.

This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address concerns about inappropriate conduct by practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Medical Executive Committee or the elimination of any particular step in the Policy.

The Medical Staff leadership and Hospital Administration shall provide education to all Medical Staff members and Allied Health Professionals regarding appropriate professional behavior. The Medical Staff leadership and Hospital Administration shall also make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy and shall institute procedures to facilitate prompt reporting of inappropriate conduct and prompt action as appropriate under the circumstances.
DEFINITION AND EXAMPLES OF APPROPRIATE CONDUCT
Thus, appropriate behavior is defined as treating others in such a way that the culture of safety is supported. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. All Medical Staff members, health professionals and other employees system-wide must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner. The following are examples for illustration only, and are not intended to be a comprehensive list:

Treating others with respect, courtesy and dignity
Conducting oneself in a professional manner
Responding to patient and staff requests in a timely fashion
Refraining from criticizing others in the presence of patients and families
Refraining from blaming others for adverse outcomes or sentinel events
Refraining from the use of foul language, shouting, yelling or rudeness
Behaving in a manner that encourages clear communication
Respecting patient autonomy and confidentiality
Respecting patient rights
Refraining from racial or ethnic slurs
Refraining from threats of violence or retribution
Refraining from actions that are reasonably felt by others to represent intimidation
Refraining from activities that could be construed as sexual harassment
Refraining from making sexual innuendos
Refraining from telling jokes that may be construed by others as offensive

DEFINITION AND EXAMPLES OF DISRUPTIVE AND INAPPROPRIATE CONDUCT
Any conduct that fails to support a collegial and safe environment is considered inappropriate and/or disruptive. Examples include, but are not limited to, the use of threatening or abusive language, profanity or similarly offensive language, inappropriate physical contact with another individual, inappropriate medical record entry, refusal to abide by the requirements of one's position within the organization, insubordination, and sexual harassment.

REPORTING OF DISRUPTIVE AND INAPPROPRIATE CONDUCT
Nurses and other Hospital employees who observe, or are subjected to, conduct that is perceived to be inappropriate, shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, shall notify any member of the Peer Review Committee and also make such reports as are required by applicable Hospital human resources policies. Any practitioner who observes such behavior by another practitioner shall notify any member of the Peer Review Committee (or its designee) directly.
The individual who reports an incident shall be requested to document it in writing. If he or she does not wish to do so, the supervisor or Peer Review Committee member may document it, after attempting to ascertain the individual's reasons for declining and encouraging the individual to do so.

The documentation should include:

the date and time of the incident;

a factual description of the concerns;

the name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident;

the circumstances which precipitated the incident;

the names of other witnesses to the incident;

consequences, if any, of the behavior as it relates to patient care, personnel, or Hospital operations;

any action taken to intervene in, or remedy, the incident; and

the name and signature of the individual reporting the matter.

The Peer Review Committee member shall forward the report to the Peer Review Committee.

The designated person shall follow up with the individual who made the report by informing him/her that the matter is being reviewed, thanking him/her for reporting the matter and instructing him/her to report any further incidents of inappropriate conduct. The individual shall also be informed that, due to legal confidentiality requirements, no further information can be provided regarding the review of the matter.

**INITIAL PROCEDURE**

The Peer Review Committee shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident.

If the Peer Review Committee determines that an incident of inappropriate conduct has likely occurred, the Peer Review Committee has several options available to it, including, but not limited to, the following:
notify the practitioner that a report has been received and invite the practitioner to meet with one or more members of the Peer Review Committee to discuss it;

send the practitioner a letter of guidance about the incident;

educate the practitioner about administrative channels that are available for registering concerns about quality or services, if the practitioner's conduct suggests that such concerns led to the behavior. Other sources of support may also be identified for the practitioner, as appropriate;

send the practitioner a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing; and/or

have a designated Peer Review Committee member(s), or the Peer Review Committee as a group, meet with the practitioner to counsel and educate the individual about the concerns and the necessity to modify the behavior in question.

The identity of an individual reporting inappropriate conduct will generally not be disclosed to the practitioner during these efforts, unless the Peer Review Committee members agree in advance that it is appropriate to do so. In any case, the practitioner shall be advised that any retaliation against the person reporting a concern, whether the specific identity is disclosed or not, will be grounds for immediate referral to the Medical Executive Committee pursuant to the Bylaws or Credentials Policy.

If the Peer Review Committee prepares any documentation for a practitioner's file regarding its efforts to address concerns with the practitioner, the practitioner shall be apprised of that documentation and given an opportunity to respond in writing. Any such response shall then be kept in the practitioner's confidential file along with the original concern and the Peer Review Committee's documentation.

If additional reports are received concerning a practitioner, the Peer Review Committee may continue to utilize the collegial and educational steps noted in this section as long as it believes that there is still a reasonable likelihood that those efforts will resolve the concerns.

**REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE**
At any point, the Peer Review Committee may refer the matter to the Medical Executive Committee for review and action. The Medical Executive Committee shall be fully apprised of the actions taken by the Peer Review Committee or others to address the concerns. When it makes such a referral, the Peer Review Committee may also suggest a recommended course of action.
The Medical Executive Committee may take additional steps to address the concerns including, but not limited to, the following:

require the practitioner to meet with the full Medical Executive Committee or a designated subgroup;

require the practitioner to meet with specified individuals (including any combination of current or past medical staff leaders, outside consultant(s), the Chair of the Governing Body or other Governing Body members if medical staff leaders, hospital management and legal counsel determine that board member involvement is reasonably likely to impress upon the practitioner involved the seriousness of the matter and the necessity for voluntary steps to improve);

issue of a letter of warning or reprimand;

require the physician to complete a behavior modification course;

impose a "personal" code of conduct on the practitioner and make continued appointment and clinical privileges contingent on the practitioner's adherence to it; and/or

suspend the practitioner's clinical privileges for 30 days or less.

The imposition of any of these actions may not entitle the practitioner to a hearing or appeal.

The Medical Executive Committee may also direct that a matter be handled pursuant to the Practitioner Health Policy.

At any point, the Medical Executive Committee may also make a recommendation regarding the practitioner's continued appointment and clinical privileges that does entitle the practitioner to a hearing as outlined in the Credentials Policy/Manual, or may refer the matter to the Governing Body without a recommendation. If the matter is referred to the Governing Body, any further action, including any hearing or appeal, shall be conducted under the direction of the Governing Body.

**SEXUAL HARASSMENT CONCERNS**

Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions:

A meeting shall be held with the practitioner to discuss the incident. If the practitioner agrees to stop the conduct thought specifically to constitute sexual harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the practitioner's file.
This letter shall also set forth those additional actions, if any, which result from the meeting.

If the practitioner refuses to stop the conduct immediately, this refusal shall result in the matter being referred to the Medical Executive Committee for review pursuant to the Credentials Policy/Manual.

Any reports of retaliation or any further reports of sexual harassment, after the practitioner has agreed to stop the improper conduct, shall result in an immediate investigation by the Peer Review Committee. If the investigation results in a finding that further improper conduct took place, the Peer Review Committee shall refer the matter to the Medical Executive Committee for a formal investigation or other steps in accordance with the Credentials Policy/Manual. Such referral shall not preclude other action under applicable hospital human resources policies. Should the Medical Executive Committee make a recommendation that entitles the individual to request a hearing under the Credentials Policy/Manual, the individual shall be provided with copies of all relevant reports so that he or she can prepare for the hearing subject to agreement of the practitioner and counsel, if any, not to retaliate in any way.

Each case will be reviewed on an individual basis and addressed appropriately.

Approved: September 1, 2009
Revised: June 29, 2010
Updated: February 1, 2011
Purpose
The purpose of this policy is to define the process and requirements for proctoring.

Circumstances Under Which a Proctoring Requirement May Be Imposed
The Medical Executive Committee may impose a requirement for proctoring at any time. The following examples of circumstances under which proctoring may be required are illustrative only, and are not intended to exclude other circumstances:

1. As a condition of initial appointment or reappointment
2. As a part of focused professional practice evaluation, such as
   a. when privileges/membership are initially granted
   b. when privileges for a new procedure are initially granted
   c. when issues affecting the provision of safe, high quality patient care are identified
3. As a part of ongoing professional evaluations (in order to maintain privileges)

Qualifications of the Proctor
Physicians providing proctoring should meet the following qualifications:

1. Member of the medical staff of Sentara Hospitals-Norfolk with privileges in the procedure being proctored;
2. Must have a staff status of Active or Associate;
3. Must have recognized proficiency with the procedure(s) being proctored – i.e., must have performed the procedure being proctored long enough and regularly enough to provide adequate oversight. This should be defined on a case by case basis.
4. Ideally the proctor should not be associated in practice with the physician being proctored. It is recognized that on occasion this will not be possible.

Physicians providing proctoring must be approved in advance of the proctoring by the relevant department chief and the Chairman of the Credentials Committee.

The physician being proctored must obtain the informed consent from the patient, informing them of the need for proctoring and the proctoring process.
Role of the Proctor
The proctor functions as a representative of a recognized peer review committee approved by the Governing Body, and should be recognized as such.

The aspects of the procedures to be proctored will be defined as a part of the specific proctoring requirement.

The procedure is posted in the name of the physician being proctored. The proctor observes the procedure. The physician being proctored may bill for the procedure.

The role of the proctor will vary depending upon the reason proctoring is required. When proctoring occurs in the setting of acquisition of new procedural skills, the role of the proctor will be that of instructor and mentor. In other circumstances, the role of the proctor will be for the sole purpose of evaluating the physician being proctored. In those circumstances, the proctor should not interact with the patient other than for the purpose of introduction and explanation of the proctoring role. The proctor should only report to the Medical Staff committee he represents.

In the event the proctor has concerns about the procedure, the proctor should take remedial action. That action could include contacting the appropriate supervisor, asking the proctored physician to stop his/her actions, if possible, or, as a last resort, to intervene personally.

The proctor must complete the appropriate case evaluation form(s) in a timely manner, at least within one week of the procedure being proctored.

The proctor must hold information related to the proctored events strictly confidential.

The Proctoring Process
The number of cases to be proctored will be defined as a part of the proctoring requirement. The number of cases to be proctored should be reasonable with the understanding that additional observation may be necessary in some cases.

The proctor must certify the applicant's competence in the procedure's performance in a format that will be designed as appropriate for each circumstance under which proctoring is required. It is appropriate that consideration be given to evaluating all or some (as appropriate) of the following dimensions of care:

- Patient selection
- Pre-operative evaluation and preparation
- Familiarity with instrumentation
- Procedural skills/judgment
Safe, expeditious completion of the procedure
Post-operative plan
Complication avoidance

It is recognized that the evaluation of these aspects of care will require significant communication between the proctor and the physician being proctored. It is the responsibility of the physician being proctored to ensure the proctoring physician has sufficient information to make the necessary evaluations.

Special Situations
If there is no specialist on the medical staff who qualifies as an expert for the procedures to be proctored, if a privilege is new to the facility, or if the physician who wishes to be proctored can document to the satisfaction of the department chief and the Chairman of the Credentials Committee that he/she has been unable to secure the agreement of any medical staff member to provide proctoring, temporary privileges may be considered for purposes of proctoring the first (or first group) of physicians to be privileged in the procedure. This documentation must be maintained in the physician’s credentials file.

Alternately, the applicant may request permission from the Sentara Hospitals-Norfolk department chief and the Chairman of the Credentials Committee for proctoring at another facility. In either of these special situations, the proctor must meet the qualifications listed below:

1. have privileges in the procedure being proctored at another acute care hospital accredited by The Joint Commission;
2. exercise those privileges in on a regular basis;
3. be able to document their competence and volume in the procedure being proctored; and
4. meet all applicable credentialing and privileging requirements at Sentara Hospitals-Norfolk and
5. be approved in advance through written notice, a copy of which, must be retained in the physician’s credentials file, of any proctored procedure by the relevant department chief and the Chairman of the Credentials Committee.

Updated February 1, 2011
Policy:
There will be a systematic process of Medical Staff Peer Review for the purpose of the evaluation of the quality of care and identification of opportunities to improve medical care.

Purpose:
To describe a review process for Medical Staff, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Certified Registered Nurse Anesthetists and define the procedure for peer review. Other health professionals employed by a medical staff member will be reviewed under the sponsoring physician.

Peer Review Committee Structure:
- The Peer Review Committee will be comprised of members from at least the following areas: surgery, anesthesia, cardiac services, OB/GYN, radiology, internal medicine, the emergency department, and hospital administrative and quality staff as appropriate.

- The Peer Review Committee reports its activity directly to the Medical Executive Committee (MEC). A report from the Peer Review Committee including select peer review issues are forwarded to and reviewed by the SHN Medical Executive Committee (MEC). Actionable peer review issues are reviewed and approved by the Medical Affairs Committee (MAC).

There are four categories of quality and peer review indicators that are part of the Medical Staff Peer Review Program:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Standard rules, regulations, general principles of medicine</td>
<td>Deviations from standard expectations of documentation or management of common patient care situations</td>
<td>• Lack of pre-operative history and physical • Inappropriate blood usage • Overuse of antibiotics</td>
</tr>
<tr>
<td>2. Unusual events</td>
<td>Event that involves patient injury, risk of injury, or adverse outcomes</td>
<td>• Unplanned return to the Operating Room • Unplanned admission to ICU • Patient injury or death during surgery • Patient injury or unanticipated death during medical care or surgery</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Examples</td>
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| 3. Rate based indicators  | Quality measures identified by department that describe important processes or outcomes of care. A target range or norms established for each indicator. Data is aggregated and reported to appropriate department or committee. | • Surgical and medical complication rates  
• Compliance with approved clinical pathways and associated standing orders  
• Cesarean section rates/VBAC rates |
| 4. Behavioral Issues      | Event that involves physician behavior in the management of patient care or interdisciplinary activity | • Anger or other inappropriate behavior toward a patient  
• Timeliness in response to clinical staff pages  
• Non-compliance with handwashing  
• Repeated violation of hospital policies or rules |

**Initiating Peer Review:**
Sources of referrals may include the hospital's event reporting system (STARS); Quality Management Referrals; patient/family letters; referrals from Risk Management, Patient Advocate, Medical Care Management, other physicians, a medical department's QI committee, Infection control, etc.; data reports based upon identified medical department quality indicators.

**Peer Review Process:**
All referrals will be screened by Quality Management staff using criteria specific to the particular indicator to determine if the case needs to be referred for peer review. (See Peer Review Screening Criteria Tools.) Serious safety events involving physicians/practitioners may be investigated using a Root Cause Analysis approach and/or Performance Management Decision Tree. Investigation of suspected substandard medical care that caused injury (or almost caused injury) analyzes a practitioner’s action(s), motive(s), and behavior at the time care was jeopardized.

For routine referrals (non-RCA or serious safety events) the QI nurse will gain as much information about the situation as possible. This may be done through review of:

• EPIC  
• Peer Review database for prior cases/trends  
• Aggregate data from reports  
• Forwarding the case for "pre-screening" by a peer physician unrelated to the case, but with appropriate expertise.
If a case does not involve a physician/practitioner or is deemed to not meet requirements, it is stored in a “fallout” file. Example – Incorrect entry of a physician’s order; this will be placed in a fallout file.

If the case involves a physician/practitioner and it meets requirements, it will be reviewed by the Chairman of the Peer Review Committee (or a designee from the Peer Review Committee). The Chairman (or designee from the Peer Review Committee) will prescreen all referrals and decide:

- It is a non-issue or no action is warranted
- It is an issue to be trended
- It needs a follow-up informational / educational letter
- It needs a letter of perspective (the physician’s/practitioner’s side of the story)
- More information is needed (including review by a peer physician unrelated to the case but within that specialty).

Letters to physicians / practitioners are prepared by the QI nurses under the direction of the Peer Review Committee Chairman. Letters are signed by the Chairman and sent to the physician/practitioner. Informational letters are sent by regular mail. Requests for letters of perspective are sent by certified mail. Educational / reminder letters regarding disruptive behaviors are sent by certified mail.

Once a physician’s/practitioner’s letter of perspective (or a pre-screened case) is received in Quality Management, it is reviewed by the Chairman of the Peer Review Committee to determine whether the case needs to be presented to the Peer Review Committee. Cases may be presented to the Peer Review Committee despite the absence of a response letter

- If medical management and documentation is deemed satisfactory by the Chairman, the case is brought to the Peer Review Committee in the Chair Report.
- If medical management and documentation is deemed questionable, the case is presented to the Peer Review Committee.

All materials relevant to the case are provided to all committee members for review prior to the meeting. The committee will discuss the case and determine if opportunities for improvement in the care provided or behaviors exhibited by the physicians and/or allied health professionals involved in the care of the patient exists. If so, more appropriate behaviors or actions will be recommended by the Committee with the goal of performance improvement. If the provider(s) involved are found to need remediation, such as additional education or training, the Committee will make the relevant recommendation or escalate the matter to the medical Staff Officers, if necessary. The Committee will also determine if system processes or resources (such as Nursing, Pharmacy, IT) contributed to the level of patient care provided and make recommendations to Hospital Administration for performance improvement in these areas.
Cases involving mid-level practitioners (NP-C, CNM, CRNAs, PA-C) or residents in which recommendations for improvement are made relative to the behavior or patient care provided by the mid-level practitioner will be attributed to the supervising physician. These cases will be identified on the supervising physician’s quality report with the following letters to designate that the case involved a mid-level practitioner or resident:

Resident – R

Mid-level Practitioner - M

When a case is complete, the Peer Review Committee reports its activity directly to the Medical Executive Committee (MEC). A report from the Peer Review Committee including select peer review issues are forwarded to and reviewed by the SHN Medical Executive Committee (MEC). Actionable peer review issues are reviewed and approved by the Medical Affairs Committee (MAC). A closure letter is sent to the physician/practitioner informing them of the committee’s findings. The case is entered into a peer review database for tracking.

All cases that are referred for peer review will be tracked in Quality Management irrespective of action taken or ultimate outcome.

**Reporting of Peer Review Determinations:**
The peer review committee reports its activity directly to the Medical Executive Committee. The final outcome of a case is confidential; conclusions reached or actions taken will not be reported back to hospital staff/patients/families. A closure letter is sent to the practitioner, informing him/her of the findings of the committee.

Results of cases that have been determined to include opportunities for improvement by the Peer Review Committee will be forwarded to the Chief of the respective department by means of a copy of the closure letter. In addition, physician specific reports are furnished to the medical staff officers and department chiefs on a periodic basis. Peer review/quality information is considered at the time of reappointment and as necessary to ensure safe and appropriate care. Peer review documents are protected from discovery by Virginia state code 8.01 – 581.016-.017 & HCQIA ‘86.

**Inappropriate or Disruptive Behavior:**
The Peer Review process can be utilized for physicians/practitioners who demonstrate inappropriate or disruptive behavior. Inappropriate or disruptive behavior is described as a style of interaction with physician, hospital personnel, patients, family members or others that interferes with patient care… that tends to cause distress among other staff and affect overall morale within the work environment, undermining productivity and possibly leading to high staff turnover or even resulting in ineffective or substandard care (AMA Report of the Council on Ethical and Judicial Affairs).

**Categories of action(s):**
- No validity to complaint / “fallout”: Complaint is determined to be invalid; the practitioner is not notified of the referral and the issue is not trended.

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• No further action at this time except to trend: Complaint is not reliable and/or difficult to validate; the practitioner is notified of the referral as a "FYI" & the behavior is trended; the issue will not be included in physician's quality report, unless the behavior continues or represents a pattern.

• Educational / reminder letter: Complaint is reliable and/or validated; a written request for a change in behavior is sent, thereby notifying the practitioner of the complaint; the behavior is trended; a Medical Staff representative is notified as a FYI; the issue will be included in the practitioner's quality report.

• VPMA conversation or conference with practitioner: Complaint is reliable and/or validated; a verbal or written request is made for a change in behavior; the behavior is trended; the Medical Staff will be notified and the issue will be included in the practitioner's quality report.

• The complaint is referred to the Medical Staff for review and/or action. Action(s) taken by a Medical Staff representative should be documented and forwarded to Quality Management for trending purposes.

Miscellaneous:
1. An efficient process of peer review is important and an average turnaround time for a case should be 90 days or less, and should not be longer than 180. If the case deviates from these time frames, the chair of the Peer Review Committee is to be notified.
2. Any trends in occurrences are reported to the medical staff Department Chiefs and are used to identify areas for improvement in organization performance projects.
3. The Credentialing Committee Chairperson or their representative and the Department Chief will review the physician / practitioner's quality report at the time of Reappointment. The quality report will include Peer Review cases that required recommendations for improvement or action(s) beyond trending.
4. External review of peer review cases is implemented in the following situations:
   a. There is a lack of sufficient physician/practitioner peers specializing in the involved physician's/practitioner's field of medicine to objectively and expertly review the records.
   b. There is a conflict of interest between the chief/chair of the department requesting the review and the involved physician/practitioner (e.g. have been or are currently partners) and there is no other physician/practitioner available to perform the review.
   c. The issue is so intricate or complicated as to require an expert in the specialized field to review the record.

Initial Approval: May 1999
Approved April 1, 2014
The manager responsible for the service being implemented will be responsible for completing this form prior to privileges being granted.

NEW PRIVILEGE RESOURCE AVAILABILITY FORM

Name of Privilege:

Resources Available To Allow Physicians To Exercise Privilege:

Space:  

Yes  No

Equipment:

Staffing:

Financial Resources:

If any of the above resources necessary to allow physicians to exercise the privilege is not available, please describe the plan to obtain the resource:

Physicians to be privileged:

Yes _____ No _____

Date of Credentials Committee meeting: __________________________
Policy: The Sentara Leigh Hospital and Sentara Norfolk General Hospital medical staff will use email as the primary means of communication for important matters.

Effective Date: December 2, 2008

Rationale:

One of the important challenges facing the medical community is communicating effectively and efficiently. This challenge is characterized by:

- Large number of individuals and groups
- Wide geographic spread
- No means of rapid mass communication
- Locating specific individuals or groups is difficult
- Limited ability to tap into the potential of multimedia
- Rising costs of traditional paper-based methods.

Many other businesses have responded to these needs through a combination of email and web-based solutions. Healthcare typically lags behind in using these technologies.

While the medical community has “muddled through” without email in the past, we have reached a critical turning point with the advent of eCare. Early experience with eCare implementation has shown the lack of an efficient and effective means of two-way communication leads to serious performance and safety issues.

The current state of email use is characterized by:

- Inconsistent use
- Inaccurate or missing email address
- No or Unclear expectations
- No clear rules of engagement
- Lack of secure means of distribution of sensitive information

As a result, the medical staff will now move forward with adoption of email as the customary standard.

EMail Requirement

- All members of the medical staff will maintain an accurate, functional email address on file with Sentara Healthcare Information Technology.
• The medical staff can use any email address they prefer for this purpose. If they do not have an email address, Sentara will set up a free email address for them using one of the free commercial providers such as Google GMail.

• Each member of the Medical Staff and the Allied Health Professional Staff of Sentara Leigh Hospital and Sentara Norfolk General Hospital is required to maintain a current email address on file. Failure to maintain a current email address will result in the automatic relinquishment of clinical privileges until a current email address is provided.

**Email Use**

• Email will be the primary means of communication for all important medical staff matters.

• Email addresses will be treated as confidential and will never be shared with a third party without the consent of the user.

• Access to the email lists will be limited to the following:
  o Hospital VPMA
  o Hospital Administrator
  o Dr. David Levin, VP, Sr. MD, eCare HN
  o Dr. Gary R. Yates, SCVP, SH, CMO
  o Dr. Gene Burke, VP @ Exec MD, CE

  Other staff who wish to use email to contact physicians will be required to work with someone on the list above to get their approval and support.

• All users agree to respect the privacy of others:
  o No Spam
  o No commercial applications / sale of personal information
  o Mass emailing should be done using “blind copy” feature
  o No “flaming” – abusive personal comments or extreme criticism

• Sensitive or confidential information will be handled with care:
  o Should NOT be sent directly via email.
  o Email link to documents instead
  o User can use link to login to secure website (MDOffice) and access documents.
  o Individual documents can also be password protected for additional security.
  o Personal Health Information (PHI) will never be sent via unsecured email.

• Violations of an email use policy will be handled by the appropriate medical staff leaders and/or committees:
o Routine, non-malicious uses will be handled thru collegial discussion and education
o Security Violations will be handled via the normal security policy and procedures,
o Behavioral issues will be handled via the normal peer-review policy and procedures.

Updated February 1, 2011
Policy

All members of the Medical and Allied Health Professional Staff are required to provide evidence of his or her PPD status on an annual basis. Medical staff members who only provide telemedicine services are exempt from this requirement.

Details

1. The tests or other documentation should be no further apart than every 12 months.
2. PPDs will be tracked and monitored the date of the most recent result on file.
3. Applicants will be required to supply evidence of a PPD status that was obtained within 12 months prior to approval of an application for appointment. The Sentara Occupational Health Department is not required to supply the test to applicants. If it is provided, the provider would be responsible for any fee that is associated with this service.
4. PPD test results should be interpreted within 48-72 hours.
5. Providers are not permitted to interpret their own test results.
6. Current medical or allied health professional staff members are permitted to obtain PPD tests from any Sentara Occupational Health Department at no charge. The Occupational Health Department may share the provider’s test results with the Medical Staff Office as a courtesy, but it remains the provider’s responsibility to ensure that the Medical Staff Office receives this information by the date of expiration.

Process

1. Notification will be sent to providers on or about the first day of the month of expiration. For example, providers with January expirations would receive notices in late December or early January that they must provide evidence of PPD status no later than January 31.
2. If the provider does not furnish Sentara with evidence of current PPD status by the end of the month of expiration, the provider will be sent a reminder at the beginning of the following month, giving a two (2) week grace period. In the example, the provider would have a grace period expiring on February 15.
3. If the provider still does not furnish Sentara with evidence of current PPD status by the end of the grace period, the provider will be sent a reminder by certified mail. The certified letter will give the provider a final grace period of ten (10) days from the date of receipt. If the provider does not
supply a current PPD by the end of the final grace period, the provider’s medical staff privileges or permission to practice will be suspended and access to eCare will be terminated.

4. If a provider’s medical staff privileges or permission to practice is suspended, the provider must supply the current PPD and payment of a reinstatement fee of $500 before a request for reinstatement can be processed. A request for reinstatement can take up to three (3) business days to be processed.

5. This relinquishment of privileges does not grant the provider a hearing right and is not reportable to either the State Board of Medicine or the National Practitioner DataBank.

Approved February 7, 2006
Revised September 3, 2013
Purpose:

This document outlines the Medical Staff policy related to conflicts of interest involving Medical Staff leaders and members of the organized Medical Staff and Allied Health Professionals brought into the hospital under the sponsorship of Medical Staff members. This policy defines disclosure requirements and defines how conflicts of interest will be addressed.

Policy:

A conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations to the Hospital, other Medical Staff, patients, and employees, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise. A conflict of interest depends on the situation and not on the character of the individual.

Medical Staff members must conduct their affairs so as to avoid or minimize conflicts of interest, and must respond appropriately when conflicts of interest arise.

The following are representative, but not all inclusive, of conflict of interest situations:

- Influence on purchases of equipment, instruments, materials or services for the Hospital from the private firms in which the Medical Staff member, or an immediate family member, has a financial interest
- Unauthorized disclosures of patient or Hospital information for personal gain
- Giving, offering, or promising anything of value, as a representative of the Hospital to any government official to enhance relations with that official or the government
- Transmission to a private firm or other use for personal gain of Hospital supported work, products, results, materials, record, or information that are not made generally available
- Influence upon the negotiation of contracts between the Hospital and private organizations with which the Medical Staff member or immediate family member has consulting or other significant relationships or will receive favorable treatment as a result of such influence
- Improper use of institutional resources for personal financial gain
• Acceptance of compensation or free services from a vendor, service provider, or contractor of the Hospital when the Medical Staff member is in a position to determine or influence the Hospital's purchases from those persons or organizations.

Procedure:

Disclosure: Each Medical Staff member and each Allied Health Professional working in the hospital under a Medical Staff member's sponsorship must complete the attached Conflict of Interest Disclosure Statement on an annual basis.

In addition, whenever a Medical Staff member is in a situation in which he or she may be potentially in violation of the above policy, that member should make full disclosure in writing of the details of the situation to request an exception. This disclosure should be submitted to the President of the Medical Staff or his designee.

The President of the Medical Staff or his designee shall review the situation and examine all facts thoroughly for apparent conflicts. Exceptions shall be granted at the sole discretion of the President of the Medical Staff or his designee. If the President of the Medical Staff or his designee determines that the Hospital would best be served by granted the requested exception, he/she may do so in writing with justification for the granting and delineating of any condition(s) placed on the approval. If the President of the Medical Staff or his designee determines that no exception should be granted, that is a final determination and there is no appeal from that decision. If the President of the Medical Staff or his designee determines that there has been a violation of this policy, he/she may meet with the Medical Staff member to agree upon appropriate resolution of the conflict, may refer the matter to the Peer Review Committee or may request that a formal investigation be initiated under the Medical Staff Bylaws.

Reporting: Suspected violations of this policy should be reported to the President of the Medical Staff or his designee. Such reports may be made confidentially.

All violations of laws or regulations must be reported.

Credentialing and Peer Review: Conflicts of interest that occur with credentialing and peer review should be handled under the terms of the relevant sections of the Medical Staff Bylaws/Credentials Policy or Manual and/or Peer Review Policy.

Approved: September 1, 2009
Updated: February 1, 2011
Notification to the Practitioner

Privileging decisions are made by the Sentara Healthcare Medical Affairs Committee at its regularly monthly meeting. Once the decision has been made, it is communicated to the practitioner via letter.

The day of the Medical Affairs Committee meeting, the Medical Staff Office faxes the practitioner a letter from the Medical Staff Coordinator. This letter notifies the practitioner that his/her request has been approved and gives the practitioner important information he/she needs to know to begin practicing, such as how to obtain a badge, dictation number, access to MD Office, etc.

The day of the Medical Affairs Committee, the Medical Staff Office mails practitioners a letter from the Chief Medical Officer (as the Chief Executive Officer’s designee) formally advising them of the Medical Affairs Committee decision. A copy of the practitioner’s approved delineation of privileges form or scope of practice is attached to this letter.

Physicians are notified about the denial or modification of privileges through the process outlined in the medical Staff Bylaws. Members of the Allied Health Professional staff are notified about the denial or modification of privileges and/or scopes of practice through the process outlined in the Medical Staff Bylaws. The notice to the practitioner of the decision makes the practitioner aware of all due process to which he or she is entitled.

If the Medical Affairs Committee modifies or denies a practitioner’s privileges or scope of practice subsequent to the appropriate appeals process, the practitioner is notified via letter sent by the Medical Staff Office no later than the end of the week the Medical Affairs Committee meets.

Dissemination of Information Regarding the Granting, Denial and/or Modification of Medical Staff Clinical Privileges and Allied Health Professional Delineation of Privileges/Scopes of Practice

The day of the Medical Affairs Committee decision, the Medical Staff Office sends an e mail to all managers and other key personnel (such as Information Technology, Security, Health Information Services) about the granting of privileges or scopes of practice.
Immediately after a decision is made regarding the modification or denial of clinical privileges or scopes of practice, the Medical Staff Office sends an e-mail to all managers and other key personnel notifying them of the modifications, but not the reason. An e-mail might read: “Effective immediately, Dr. ______ is not eligible to practice at Sentara Leigh Hospital and Sentara Norfolk General Hospital.”

No later than the day following the Medical Affairs Committee meeting, the Medical Staff Coordinator “grants” any appropriate privilege(s) in the Privileges Module, which is the database that allows hospital staff to know the privileges practitioners are entitled to exercise so that they can ensure that practitioners are practicing within their clinical privileges or scopes of practice. This database is available through Wavenet.

Approved May 25, 2010
Updated February 1, 2011
When participating in social media sites such as MySpace, Facebook, LinkedIn, YouTube or Twitter, or blogs or any other sites where text, images or videos can be posted (referred to as “internet activity” for the purpose of this policy), Medical Staff members are expected to behave in a professional manner and preserve patient confidentiality.

While publication of a patient’s demographic information is an obvious HIPAA violation, even an anonymized description of the events of a clinical encounter may be sufficient to jeopardize patient confidentiality and is therefore prohibited.

Medical Staff members will be summoned to appear before the Medical Staff Officers to account for any internet activity, personal or business-related, that compromises patient confidentiality as outlined in the HIPAA regulations, as well as for violations of the prohibited unprofessional activities described below. Consequences for confirmed violations shall be commensurate with the nature and severity of the offense as determined by the Medical Staff Officers and may range from written reprimand to restriction, suspension, or revocation of privileges.

Prohibited Activities:

- Internet activity that interferes with, or distracts from, patient care or customer service.
- Posting of photographs or video of any part of a patient’s body, whether or not they identify the patient.
- Posting of patient information or images that contain patient information.
- Posting of the details or events of any clinical encounter, even if such a description is rendered anonymous.
- Use of the Sentara logo in any internet activity not managed by Sentara Healthcare.
- Activities that violate intellectual property rights, copyright, fair use and financial disclosure laws.

Internet activity related to Sentara, members of the medical or hospital staff, employees, physicians, customers, vendors, partners or competitors must not be defamatory, harassing, discriminatory, or in violation of any applicable law.

Photographs and video taken on Sentara property or at a Sentara sponsored event must not be shared on an internet posting without receiving permission from the Sentara Public Relations Department.

Internet activity must not be represented as an official Sentara-sponsored site/page, nor can the internet posting claim to speak on the company’s behalf.

Approved July 5, 2011
Sentara Leigh Hospital
Sentara Norfolk General Hospital

Medical Staff Disaster Preparedness Policy

Purpose:
It is the purpose of this document to provide guidelines for Medical Staff preparation in the event of a disaster.

Policy:
In preparation for threatened disaster, the Hospital President or VPMA along with the President of the Medical Staff or his successor or designee, may require physicians who deliver essential services to take call within the hospital. This call will begin at a time when Administration determines that transportation to and from the hospital may be compromised and that communications may not remain intact. In-hospital call will end when the clinical need is satisfied and when communication is reliable and physicians are able to travel to and from the hospital. Medical Staff who do not wish to stay in-house or who are unable to stay in-house (such as those who cover more than one hospital) may be required to arrange for a substitute physician in the same specialty who will stay in the hospital. Specialty coverage may come from a different group. In the event of limited physician coverage across Sentara hospitals, the Corporate Command Center and Chief Medical Officer of Sentara Healthcare will engage to make priority coverage decisions. In the event where an extended stay in the hospital is anticipated or necessary, each service is expected to make formal arrangements for relief physician coverage and this arrangement should be conveyed to the hospital’s Incident Command Center.

Responsibility:
On call physicians who are not staying in the hospital are expected to periodically check for the hospital’s ability to reach them. This should be done through the hospital’s Incident Command Center. If communication is not possible, these physicians should come to the hospital’s Incident Command Center as soon as it is safe to do so.

On call physicians may be called to report to the Incident Command Center by the President of the Medical Staff, his successor/designee or the VPMA, should the conditions and needs warrant the presence of a medical staff member.

Anticipated disasters would generally include the following types of physicians for in-hospital call. Others may be required to take in-house call by the President of the Medical Staff, Hospital President or VPMA.
Expected in-house coverage is recommended for the following:

**SLH:**
- Anesthesia
- Critical Care
- General Surgery
- Hospitalists
- ED
- Obstetrics
- Pediatrics
- Radiology

**SNGH:**
- Anesthesia / Cardiac Anesthesia
- Critical Care
- General Surgery
- Hospitalists
- Interventional Cardiology
- Cardiac Surgery
- ED
- Obstetrics
- Pediatrics
- Neurosurgery
- Radiology / Interventional Radiology

*Approved July 3, 2012*
Policy

The medical staff of Sentara Leigh Hospital and Sentara Norfolk General Hospital has a commitment to always keep patients and employees safe. Immunization against influenza has been proven to reduce the risk of transmission of this potentially fatal disease. The Centers for Disease Control and Prevention, the American Hospital Association, and other regulatory agencies and professional organizations recommend that healthcare workers be immunized against influenza or require that a surgical mask be worn during influenza season. In accordance with these recommendations, all Medical Staff and Allied Health Professionals shall be required to participate in the annual influenza prevention campaign as follows: 1) obtain recommended influenza vaccination from Sentara or another provider or 2) decline vaccination. Those who decline vaccination will be required to wear a mask during influenza season.

Definitions

All Medical Staff: All physicians with a medical staff appointment and/or clinical privileges and allied health professionals with clinical privileges or permission to practice at Sentara Leigh Hospital and Sentara Norfolk General Hospital.

Declination: Decline, refuse vaccination.

Influenza Season: Time period during which the Virginia Department of Health notes prevalent outbreaks of influenza activity in the state. The exact time period will be determined annually.

Required: Mandatory; not optional. Declination will only be acceptable for medical or religious reasons.

Verification: Review, validation, and documentation by Occupational Health or through MD Office by the Medical Staff member or Allied Health Professional self-reporting influenza vaccination administered by another provider.
Monitoring

- The Occupational Health Department in conjunction with the Medical Staff Office shall be responsible for monitoring vaccination compliance.

- All Medical Staff and Allied Health Professionals vaccinated by Occupational Health will be entered into the database. Those vaccinated by another provider shall self-report into MD Office. It is recommended that proof of vaccination be worn on one's identification badge.

Outcomes

- Medical Staff and Allied Health Professionals who decline vaccination will be required to wear a surgical mask while working during the influenza season. Practitioners that fail to wear a mask will be contacted by the VPMA, Department Chief and/or President of the Medical Staff.

Related Documents

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<th>Regulatory References</th>
<th>CDC Guidelines for Seasonal Flu</th>
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Approved December 4, 2012
On-Call Schedule

1. Each department chief, on behalf of the Hospitals, will be responsible for developing an on-call rotation schedule that includes the name and pager number of each physician in the department who is required to fulfill on-call duties.

2. The on-call rotation schedule may be general (e.g., medicine or surgery) or by specialty (general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined by the Hospitals and implemented by the relevant department chiefs. The Medical Executive Committee will review the on-call schedule and make recommendations to the Vice President of Medical Affairs when formal changes are to be made or when legal and/or operational issues arise.

3. Members of the Medical Staff have an obligation, but not a right, to share on-call duties. Medical Staff members who are relieved of on-call responsibilities for any reason may be assigned other duties so that all members share as equitably as possible in Medical Staff responsibilities. Removing a member from the on-call schedule, for any reason, does not trigger the hearing and appeals procedures in the Medical Staff Bylaws.

4. The department chief will consider the needs of patients and the hospital in developing the on-call rotation, including when certain specialties will not be covered because of a lack of physicians. When there are a limited number of physicians available to provide call coverage, physicians may be required to provide call coverage, at least once every four days. At the discretion of the department chief, the call requirement may be more frequent.

Response to Call

5. When an on-call physician is contacted by the Emergency Department and requested to respond, the physician must:

   (a) be immediately available, at least by telephone, to the Emergency Department; and

   (b) respond in person, if so requested, within a reasonable time period. Generally, response is expected within a range of 30 to 45 minutes. The Emergency Department physician, in consultation with the on-call physician, will determine whether the patient's condition requires the on-call physician to see the patient as soon as possible.
The determination of the Emergency Department physician will be controlling and will be recorded in the medical record.

6. If the scheduled on-call physician is unable to respond due to circumstances beyond the physician's control, the Emergency Department physician will determine whether to attempt to contact another specialist on the Medical Staff or arrange for a transfer pursuant to this Policy.

7. Members who are on call should not inquire about the individual's insurance status or ability to pay before coming to the Emergency Department. Therefore, Hospital employees will be instructed not to disclose to the on-call physician financial information pertaining to the presenting individual.

Transfer Arrangements

8. When possible, transfer arrangements with another hospital that can provide specialty service should be made to cover that service when there is no on-call physician scheduled to provide coverage at the Hospitals. If a patient presents needing care when a specialty is not covered, the patient will be transferred in accordance with applicable transfer arrangements. In the absence of a transfer agreement, the Hospitals should have a policy or protocol that outlines the steps to be followed in these situations.

Resignation of Privileges

9. As a general rule, physicians will not be permitted to resign privileges at the Hospitals that are included in the core for their specialty and may be required to participate in a general on-call schedule even if they have limited their private practice. Physicians will be expected to maintain sufficient competence for all privileges included within the core. If a physician does not feel clinically competent to take general call, it will be the physician's responsibility to arrange for appropriate coverage. If a physician responds to a call and requires additional expertise to take care of the patient, the physician should attempt to stabilize the patient and then request an appropriate consult or institute an appropriate transfer, whichever is in the patient's best interest.

10. Members of the Medical Staff will not be permitted to resign specific clinical privileges for the purpose of avoiding on-call responsibility.

Follow-Up Care

11. An on-call physician is responsible for the care of a patient through the episode that created the emergency medical condition, including one office follow-up visit related to that episode. An on-call physician shall not, in the Hospitals or during the office follow-up visit, require insurance information or a copayment before assuming responsibility for care of the patient.
**Allied Health Professionals**

12. Physician Assistants ("PAs") and Advanced Practice Registered Nurses ("APRNs") may be used to assist the on-call physician in responding to call. Any decision to use a PA or an APRN to respond initially to the Emergency Department should be made by the on-call physician in conjunction with the Emergency Department physician. (If the on-call physician and the Emergency Department physician do not agree, the Emergency Department physician shall be the final decision-maker.) This decision shall be based on the patient's medical needs and the capabilities of the Hospitals and must be consistent with Hospital policies and/or protocols.

**Enforcement**

13. An on-call physician's unavailability when on call, refusal to respond to a call from the Emergency Department, or any other violation of this Policy is a serious matter. Such violations can result in an investigation of the Hospital and the physician involved, a fine of up to $50,000 per incident, civil lawsuits, and/or exclusion from participation in the Medicare and Medicaid programs for the Hospital and/or the physician.

Accordingly, a refusal or failure of an on-call physician to respond timely shall be reported immediately to the President of the Medical Staff and the Vice President of Medical Affairs, who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Executive Committee for further investigation and appropriate disciplinary action. Otherwise, appropriate action may be imposed.

This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address violations under this Policy. However, a single violation or a pattern of violations may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Medical Executive Committee or the elimination of any particular step in the Policy.

**Approved March 5, 2013**
Sentara Leigh Hospital  
Sentara Norfolk General Hospital  
Medical Staff Locum Tenens Policy

**Background:**
Locum tenens providers have historically been used to provide temporary coverage for a lapse in services or adequate staffing in a particular specialty. However, credentialing locum tenens providers is challenging as they tend to have many hospital affiliations, state licenses, and a lack of familiarity with hospital medical staff leadership. They also may not form relationships with other physicians at the hospitals at which they practice, making it difficult to identify physicians that can attest to their clinical competence.

**Policy:**
The Medical Staff of Sentara Leigh Hospital and Sentara Norfolk General Hospital prefers for locum tenens providers not to be utilized, except at times of emergent need to maintain services that would be uncovered or at times to meet uncovered physician shifts over an extended period. If locum tenens providers are used, there will be additional requirements and costs for the processing of their applications to the medical staff.

**Procedure:**
If a professional group wishes to utilize a locum tenens provider to provide coverage, they must be sponsored by an active member of the medical staff who is in good standing and is not a locum tenens provider. The medical staff member must interview the locum tenens provider and submit a completed Locum Tenens Form, to be considered with the locum tenens provider's application. The Credentials Committee will only consider the application with this documentation, which will allow the medical staff leadership to determine whether the medical staff member has sufficiently evaluated the candidate and recommends them for approval. The medical staff will attempt to accommodate the requested start date, but cannot guarantee approval of any candidate.

There will be a processing fee of $500 that will need to be paid before the provider may begin work. This fee is non-refundable, regardless of whether the applicant is approved to provide coverage.

**Approved May 7, 2013**
Approval History: 7/31/06, 10/3/06, 1/2/07, 12/4/07, 2/5/08, 4/1/08, 7/1/08, 12/2/08, 3/3/09, 6/2/09, 9/1/09, 1/5/10, 5/25/10, 6/29/10, 10/5/10, 2/1/11, 7/5/11, 7/3/12, 8/7/12, 9/4/12, 10/2/12, 11/6/12, 12/4/12, 3/5/13, 5/7/13, 8/6/13, 9/3/13, 4/1/14, 8/5/14, 10/7/14
These policies were approved the ___ day of ________, 20__. 

Signed:

__________________________________
President of the Medical Staff
Sentara Leigh Hospital

__________________________________
President of the Medical Staff
Sentara Norfolk General Hospital

__________________________________
Chairman, Medical Affairs Committee